Improving MDS Accuracy

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Course Objectives

Upon completion of this course, the participant will be able to:

- Interpret DAVE Analytic Findings to improve the coding of an MDS Assessment.
- Discuss and review the Top 5 discrepancy items for Sections G, I, J, O, and P of the MDS Assessment.
- Apply this knowledge to complete a comprehensive medical record review and complete Section G of the MDS Assessment. Reconcile this assessment with the DAVE Team review.

MDS Accuracy has an effect on:

- Resident's Care Plan
- Payment
- Quality Indicators
- Quality Measures

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Top 5 MDS Sections with Highest Discrepancies

1. Section P – Special Treatments and Procedures
2. Section I – Disease Diagnoses
3. Section O – Medications
4. Section J – Health Conditions
5. Section G – Physical Functioning and Structural Problems

Section P: Special Treatments and Procedures



Top 5 Items with Most Discrepancies in Section P

1. P8 – Physicians Orders
2. P7 – Physician Visits
3. P1bcB – Physical Therapy Total Number of Minutes
4. P1bbB – Occupational Therapy Total Number of Minutes
5. P1bcA – Physical Therapy Total Number Days

P8: Physician Orders – 14 Day Look Back

- **Intent**
  - Record **NUMBER OF DAYS** during past 14 days in which physician has changed orders.

- **Definition**
  - Included written, telephone, fax, or consultation orders for new or altered treatment.
  - Does **NOT** include standard admission orders, return admission orders, renewal orders or clarifying orders without changes.

P8: Physician Orders – 14 Day Look Back

Clarifications

- Do **not** count:
  - Sliding scale dosage schedule as an order change. (Count the initial order.)
  - Orders written by pharmacists.
  - Medicare Certification.
  - Several different order changes are made on same day– code as 1 day in which orders were changed.
  - PRN orders as a change. (Count the initial order.) When a PRN order was already on file, the potential need for the service had already been identified. Notification of the physician that the PRN order was activated does not constitute a new or changed order.
  - Orders for transfer of care to another physician.

P8 – Physicians Orders

Common Reasons for Discrepancy:

- Not using 14 day look back period
- Counting number of orders vs. number of days
- Including admission orders, renewals without change or clarification orders
- Not including written, telephone, fax or consultation orders for new or altered treatments
- Counting sliding scale dosage schedule to cover different dosages depending upon lab values
- Miscalculation

Reference Source: RAI Manual, August 2003, page 3-205

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P7: Physician Visits – 14 Day Look Back

- **Intent**
  - Record **NUMBER OF DAYS** during past 14 days a physician examined resident.
  - Examination can occur in facility or in physician's office.
- **Definition**
  - Also include an authorized physician assistant, or nurse practitioner, or clinical nurse specialist working in collaboration with the physician.
  - Includes MD, Doctor of Osteopath, podiatrist, or dentist who is either the primary physician or consultant.
  - Does not include visits by Medicine Men nor licensed psychologist (PhD). (Record a PhD visit in P2b.)

Refer to CMS Memorandum: S&C-04-08, November 2003

P7: Physician Visits – 14 Day Look Back

- **Physician Exam**
  - May be a partial or full exam at the facility or physician's office.
  - Does not include ER exams.
  - If the resident was examined by a physician during an unscheduled emergency room visit, record the number of times this happened in the last 90 days in Item P6, "Emergency Room (Visits)."
- **Clarifications**
  - Resident evaluated by physician at dialysis or radiation therapy, can be coded as a physician visit.
  - Documentation of evaluation should be included in clinical record.

P7 – Physician Visits

Common Reasons for Discrepancy:

- Not using 14 day look back period
- Counting documentation by staff that physician visited vs. the number of days the physician examined the resident
- Not including examinations that occur in physicians offices
- Including exams conducted in the emergency room
- Not including residents evaluated at a dialysis or at radiation therapy. Documentation of the physician's evaluation should be included in the clinical record.
- Miscalculation

Reference Source: RAI Manual, August 2003, page 3-204

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P1b: Therapies – SLP/OT/PT – 7 day look back

- Therapies that occurred after admission/readmission to nursing facility,
- Ordered by a physician, and
- Performed by a qualified therapist.
- Includes only medically necessary therapies.
- Includes only therapies ordered by a physician, based on therapist assessment and treatment plan documented in clinical record.
- Therapy treatment can occur either inside or outside the facility.

P1b: Therapies – Intent

Record number of days and total number of minutes (at least 15 minutes a day) in last 7 days.

- **Speech-Language Pathology, Audiology Services**
  - Licensed Speech-language Pathologist
- **Occupational Therapy**
  - Services provided or directly supervised by a licensed OT.
  - An OTA may provide therapy (under direction of licensed OT) but not supervise others (Aides or volunteers) giving therapy.
- **Physical Therapy**
  - Services provided or directly supervised by a licensed PT.
  - A PTA may provide therapy (under direction of licensed PT) but not supervise others (Aides or volunteers) giving therapy.

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P1b: Therapies – Process

- Review clinical record.
- Consult with each of the qualified therapists.

P1b: Therapies – Coding

- **Box A**
  - # of days therapy given for 15 mins or more in last 7 calendar days.
- **Box B**
  - # of total mins therapy given in last 7 days, even if you entered “0” in Box A (e.g. less than 15 mins of therapy provided).
  - The time should only include actual treatment time.
- Initial evaluation time may not be counted, but subsequent evaluations, conducted as part of the treatment process, may be counted.

P1b: Therapies – Clarifications

- **Do NOT:**
  - Include therapies that occurred while an inpatient at a hospital, rehab center, or other nursing facility, or from home care.
  - Code routine wound care, applying/changing dressings, should not be coded as therapy.
  - Include documentation time and initial evaluation.
  - Count services requested by family or resident that are not medically necessary in P1b.

P1b: Therapies – Clarifications

- **Do NOT:**
  - Convert units to minutes.
    - For MDS purposes, conversion from units to minutes is **NOT** appropriate.
    - The actual minutes are the only appropriate measures that can be counted for completion of P1b.
  - Code maintenance treatments in P1b, even if performed by a licensed therapist. (Code in P3.)
  - Count skilled care provided ***independently*** by Aides.
    - Aides cannot independently provide skilled care.
    - Aides performing therapy treatments may only be coded when the services are performed under line of sight supervision by a licensed therapist ***when allowed by state law***.

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P1b: Therapies – Clarifications

- **May include**:
  - Set up time.
  - Start of treatment time when a resident begins the first treatment activity or task and end of treatment time when they finish with the last apparatus.
  - Whirlpool treatment, ordered by physician to be performed by or under supervision of a PT.
  - Reevaluations conducted during the course of a therapy treatment.

P1b: Therapies – Calculating Group Therapy

- For groups of **four or fewer residents per supervising therapist (or assistant)**, each resident is coded as having received the full time in the therapy session.
- For example, if a therapist worked with three residents for 45 minutes on training to return to the community, each resident received 45 minutes of therapy so long as that **does not exceed 25% of his/her therapy time per therapy discipline**, during the 7-day observation period.
- Remember, code for the resident's time, not for the therapist's time.
- **Note:** The 25% rule **only** apples to **Medicare A** residents.

P1b: Therapies – Calculating Group Therapy

Formula:

- Total # of Therapy Minutes – Group Therapy Minutes = Actual individual Therapy Minutes
- Actual Individual Therapy Minutes X 1/3 (or .33) = Not to Exceed # of Group Therapy Minutes
  - Compare the # of Not to Exceed Group Therapy Minutes with the # of Reported Group Therapy Minutes.
    - If the # of Reported Group Therapy Minutes is ***less than*** the Not to Exceed # of Minutes, use the Reported Group Therapy Minutes to code on the MDS.
    - If the # of Reported Group Therapy Minutes is ***greater than*** the Not to Exceed # of Minutes, use the Not to Exceed # of Group Therapy Minutes to code on the MDS.

P1b: Therapies – Calculating Group Therapy

Example:

- The PT reported 400 minutes, but 110 of those were in group.

- How many minutes are allowed to be coded on the MDS?

P1b: Therapies – Calculating Group Therapy

Answer:

- The PT reported 400 minutes, but 110 of those were in group.
- Actual individual minutes were 290. (400-110=290)
- Multiply the number of individual minutes by 1/3 to identify the not to exceed number of group minutes. (290 X .33 = 96)
- Add the individual minutes to the not to exceed number of group minutes. (290 + 96 = 386)
- Allowed to code 386 minutes on the MDS.

P1bcB – Physical Therapy Total Number of Minutes

Common Reasons for Discrepancy:

- Miscalculation of therapy minutes
- Including initial evaluation time by therapist
- Logs documenting the number of minutes are not provided or does not match the minutes coded on the MDS

Reference Source: RAI Manual, August 2003, pages 3-186 to3-187

P1bbB – Occupational Therapy Total Number of Minutes

Common Reasons for Discrepancy:

- Miscalculation of therapy minutes
- Including initial evaluation time by therapist
- Logs documenting the number of minutes are not provided or does not match the minutes coded on the MDS

Reference Source: RAI Manual, August 2003, pages 3-186 to 3-187

P1bcA – Physical Therapy Total Number of Days

Common Reasons for Discrepancy:

- Miscalculation of therapy days
- Logs documenting the number of days are not provided or does not match the days coded on the MDS

Reference Source: RAI Manual, August 2003, pages 3-186 to 3-187

Section I: Disease Diagnosis

Top 5 Items with Most Discrepancies in Section I

1. I1nn – Allergies
2. I2j – Urinary Tract Infection
3. I1l – Arthritis
4. I1oo – Anemia
5. I1k – Other Cardiovascular Disease

Disease Diagnoses: Intent

Code those diseases or infections which have a relationship to the resident's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death. These are the conditions that drive the current care plan.

- Require physician documented diagnosis in the clinical record.
- Do not include conditions that have been resolved or no longer affect the resident's functioning or care plan.
- Check condition *only* if condition meets the description in I1.

Nursing Monitoring--Includes clinical monitoring by a licensed nurse (i.e., serial blood pressure evaluations, medication management, etc).

I1: Diseases Definitions– 7 day look back

- Heart/Circulation
  - I1k Other Cardiovascular Disease
- Musculoskeletal
  - I1l Arthritis
- Other
  - I1nn Anemia
  - I1oo Allergies

Disease Diagnoses – Process and Coding

- Consult transfer documentation and medical record.
- Accept statements by the resident that seem to have clinical validity. Consult with a physician for confirmation. A physician diagnosis is required to code the MDS.
- Check a disease item *only* if the disease has a relationship to current ADL status, cognitive status, behavior status, medical treatment, nursing monitoring, or risk of death.
- Physician involvement in this part of the assessment process is crucial.
- *Do not* record any conditions that have been resolved and no longer affect the resident's functional status or care plan, as confirmed by a physician.

I1nn – Allergies

Common Reasons for Discrepancy:

- Omitting allergies documented in medical record.
- Excluding allergies to foods, environmental substances e.g. dust pollen and animals.

Reference Source: RAI Manual, August 2003, page 3-130

Other Discrepant Items in Section I

I1l – Arthritis

I1oo – Anemia

I1k – Other Cardiovascular Diseases

Common Reasons for Discrepancy:

- Including those diagnoses which do not have a relationship to the resident's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death.
- No physician-documented diagnosis in clinical record.

Reference Source: RAI Manual, August 2003, page 3-127

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I2: Infections – 7 day Look Back

- Urinary Tract Infection (UTI)
  - Includes chronic and acute symptomatic infections in last 30 days.

Infections: Process and Coding

- UTI includes chronic and acute symptomatic infections in the last 30 days.
- Check this item only if there is current supporting documentation and significant laboratory findings in the clinical record.
- For a new UTI condition identified during the observation period, a physician's working diagnosis of UTI provides sufficient documentation to code the UTI, as long as the urine culture has been done and awaiting results.
- The diagnosis of UTI, along with lab results when available, must be documented in the resident's clinical record. However, if it is later determined that the UTI was not present, staff should complete a correction to remove the diagnosis from the record.

I2j – Urinary Tract Infection

Common Reasons for Discrepancy:

- Not using the 30 day look back period
- Coding this item when there is no current supporting documentation and significant laboratory findings in the clinical record

Reference Source: RAI Manual , August 2003, page 3-136

Section O: Medications



Top 5 Items with Most Discrepancies in Section O

1. O1 – Number of Medications
2. O3 – Injections
3. O4e – Diuretic
4. O4c – Antidepressants
5. O4a – Antipsychotic

O1: Number of Medications – 7 Day Look Back

- **Intent**
  - Determine the number of different medications (over-the-counter and prescription drugs) the resident has received in the past 7 days.

O1: Number of Medications – Process

- Count:
  - The number of different medications *(not the number of doses or different dosages) administered* by any route at any time during the last 7 days.
  - Any routine, prn, and stat doses given.
  - Topical preparations, ointments, creams used in wound care (i.e., Elase), eye drops, vitamins, and suppositories.
  - Any medication that the resident administers to self, if known.
  - If resident takes both the generic and brand name of a single drug, count as only 1 medication.
  - Antigens and vaccines.
- Do **NOT** count:
  - Topical preparations that are used for preventive skin care (i.e. moisturizers and moisture barriers).

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O1: Number of Medications – Coding

- Write the appropriate number in the answer box.
- Count *only* those medications actually administered and received by the resident over last 7 days.
- DO NOT count medications ordered, but not given.

O1: Number of Medications – Clarifications

If a dietary supplement, given to a resident between meals, has a vitamin as one of its ingredients, code as a dietary supplement, *not* as a medication.
Examples:

1. **If resident receives a daily Vitamin C capsule, add it to the medication count in number of medications (O1).**
2. **Resident receives a dietary supplement between meals and the label contents specify that Vitamin C (or any other vitamin, etc) is one of the ingredients, code K5f=√, for dietary supplement between meals.**
3. **Basic TPN solution itself (that is, the protein/carbohydrate mixture or a fat emulsion)is *not* counted as a medication. Use of TPN is coded in Section K. Medications, such as, electrolytes, vitamins, or insulin, which have been added to TPN solution, are considered medications and should be coded in this section.**

O1: Number of Medications – Clarifications (continued)

- Herbal and alternative medicine products are considered to be dietary supplements by the FDA.
- All medications used by the resident in the 7 Day assessment period need to be counted in Section O. All medications administered off-site (dialysis or chemotherapy) must be considered when completing this item.
- Combination products such as Corzide (which contains a diuretic and a beta-blocker) are counted as 1 medication.
- Administration of Epogen should be recorded in several places in Section O, depending on its route of administration and date of initiation.

O1: Number of Medications – Clarifications (continued)

- Heparin included in a saline solution used to irrigate a “heparin lock” is not counted in this item.
- Each type of insulin that a resident receives should be counted separately.
- Ensure or any nutritional supplement is not counted as a medication for coding in Section O.
- Record suppositories in Item O1, Number of Medications. Facilities in states using Section U, also record in Section U.

O1: Number of Medications – Clarifications (continued)

- Vitamin B12 Injections
  - If resident received an injection of Vitamin B12 prior to the observation period, code in item O1.
  - Determine if a long acting medication is still active based on physician, pharmacist, and/or PDR input.
  - Do not code Vitamin B12 injections in Item O3 (injections) if it was given outside of the observation period.

O1 – Number of Medications

Common Reasons for Discrepancy:

- Not using 7 day look back period
- Miscalculation
- Not including routine, PRN and stat doses
- Not capturing medications administered in hospital during 7 day look back period

Reference Source: RAI Manual, August 2003, page 3-176

O3: Injections – 7 Day Look Back: Intent and Coding

- Determine the number of days during the last 7 days that resident received any type of medication, antigen, vaccine, by subcutaneous, intramuscular or intradermal injection.
- Although antigens and vaccines are considered “biologicals” and not medication per se, it is important to track when they are given to monitor for localized or systemic reactions.
- This category ***does not*** include IV fluids or medications. (Code in Item P1ac.)
- Record the number of **DAYS** in the answer box.

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O3: Injections – Clarifications

- There is no item for subcutaneous pumps on the current MDS. Code the MDS as follows:
  - 01 Count the medication as a medication.
  - 02 Identify if this was a new medication or not.
  - 03 Code **only** the number of days that the resident actually required a subcutaneous injection to restart the pump.

- Tests or vaccinations
  - If a test or vaccination is provided on 1 day and another vaccine provided on the next day, code “2” for the number of days received for injections.
  - If both injections were administered on the same day, code “1”.

O3 – Injections

Common Reasons for Discrepancy:

- Not using 7 day look back period
- Miscalculation
- Counting number of injections vs. number of days
- Including IV medications
- Not including PPDs

Reference Source: RAI Manual, August 2003 page 3-178

O4: Days Received the Following Medication – 7 Day Look Back

- **Intent:**
  - Record the number of days that the resident received each type of medication listed in the past 7 days:
    - Antipsychotics*
    - Anti-anxiety
    - Antidepressants*
    - Hypnotics
    - Diuretics*

** Indicates the types of medications that DAVE found most discrepant.*

- Includes any of these medications given by any route in any setting.

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O4: Days Received the Following Medication – Process and Coding

- Review clinical record for documentation that a medication was received during the last 7 days.
- New admission review transmittal records.
- Enter the number of days each listed medication was received in last 7 days.
- New admission, if it is clearly documented resident received any type of medication listed at sending facility, record the number of days received.
- If transmittal records are not clear or do not reference resident received one of these medications, record “0”.

O4: Days Received the Following Medication – Clarification

- Code medication according to a drug's pharmacological classification, not how it is used.
  - Be sure to consult an FDA-approved classification list.
  - Do not rely on Internet sources for drug classifications.

O4e – Diuretic

Common Reasons for Discrepancy:

- Not using 7 day look back period
- Miscalculation
- Not capturing medications administered in hospital during 7 day look back period
- Counting the number of doses vs. number of days received

Reference Source: RAI Manual, August 2003, page 3-180

O4a – Antipsychotic and O4c – Antidepressants

Common Reasons for Discrepancy:

- Not using 7 day look back period
- Miscalculation
- Not capturing medications administered in hospital during 7 day look back period
- Counting the number of doses vs. number of days received
- Not coding medication according to pharmacological classification vs. how it is used

Reference Source: RAI Manual, August 2003, page 3-180

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Section J: Health Conditions



Top 5 Items with Most Discrepancies in Section J

1. J5b – Stability of Conditions – Acute Episode/Flare Up
2. J5a – Stability of Conditions – Conditions/Diseases make resident unstable
3. J1g – Edema
4. J1h – Fever
5. J2a – Pain Symptoms – Frequency

J5: Stability of Conditions – 7 Day Look Back

- **Intent**:
  - Determine resident's disease or health conditions present over the last 7 days are acute, unstable, or deteriorating.
- **Definitions**
  - Condition/Diseases make resident's cognitive, ADL, mood or behavior patterns unstable (fluctuating, precarious, or deteriorating).
  - Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem.

J5: Stability of Condition – Process and Coding

- Observe resident.
- Consult staff members, especially resident's physician.
- Review clinical record.
- Check all that apply during the last 7 days.

J5b: Stability of Conditions – Acute Episode/Flare Up

Common Reasons for Discrepancy:

- Not using 7 day look back period
- Not capturing symptoms of an acute health condition (new MI), a recurrent (acute) condition (UTI), or an acute phase of a chronic condition (SOB, edema, and confusion in a resident with CHF)

Reference Source: RAI Manual, August 2003, page 3-147

J5a: Stability of Conditions – Conditions/Diseases Make Resident Unstable

Common Reasons for Discrepancy:

- Not using 7 day look back period
- Not capturing changes in residents conditions that makes the residents cognitive, ADL, mood or behavior patterns unstable

Reference Source: RAI Manual, August 2003, page 3-147

J1: Problem Conditions – 7 day Look Back

- **Intent:**
  - Record specific problems or symptoms that affect or could affect the resident's health or functional status, and to identify risk factors for illness, accident, and functional decline.

J1: Problem Conditions – Process and Coding

- Ask resident if they have experienced any of the listed symptoms.
- Review clinical record.
- Consult with facility staff and resident's family.
- Observe the resident directly, if possible.
- Check all conditions which occurred within the particular look back period.

J1: Problem Conditions – Other

- J1g Edema
  - Includes all types of edema i.e., dependent, pulmonary, pitting.
- J1h Fever
  - Temperature is 2.4 degrees greater than the baseline temperature.
  - Baseline temperature may have been established prior to the ARD.

J1g – Edema

Common Reasons for Discrepancy:

- Not using 7 day look back period
- Omitted coding of edema when documented in medical record

Reference Source: RAI Manual, August 2003, page 3-139

J1h – Fever

Common Reasons for Discrepancy:

- Not using 7 day look back period
- Documenting a fever that is not 2.4 degrees greater than a baseline temperature
- Omitted coding of fever when documented in medical record

Reference Source: RAI Manual, August 2003, page 3-139

J2: Pain Symptoms – 7 day Look Back

- **Intent:**
  - Record the **frequency** and **intensity** of signs and symptoms of pain.
- **Pain Definition:**
  - Pain refers to any type of physical pain or discomfort in any part of the body.
    - May be localized or generalized
    - May be acute or chronic
    - May be continuous or intermittent
    - May occur at rest or with movement
- Pain is very subjective; pain is whatever the resident describes.

J2: Pain Symptoms – Process and Coding

- Ask resident if they have pain and to describe the pain.
- Observe the resident for indicators of pain.
- Ask the CNA and therapist who work with the resident if the resident had complaints or indicators of pain in the last 7 days.
- Code for the frequency of pain during the last 7 days in J2a. Code the highest intensity of pain that occurred during the observation period in J2b.
- Code presence or absence of pain, regardless of pain management efforts; i.e, breakthrough pain.

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J2a: Pain Symptoms – Frequency

- Intent:
  - How often does resident complain or show evidence of pain.
    - **0** – No Pain (Skip to item J4)
    - **1** – Pain Less than Daily
    - **2** – Pain Daily
- Facilities should have a consistent, uniform and standardized process to measure and assess pain.
- If having difficulty determining the exact frequency of pain, code for the more severe level of pain.
  - Rationale:
    - Residents having pain will usually require further evaluation to determine the cause and to find interventions that promote comfort.
    - Pain control often enables rehabilitation, greater socialization and activity involvement.

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J2a: Pain Symptoms – Frequency

Common Reasons for Discrepancy:

- Not using 7 day look back period
- Not capturing how often the resident complains or shows evidence pain
- MAR documents pain and pain medication received – MDS coded as No Pain

Reference Source: RAI Manual, August 2003, page 3-142

Section G: Physical Functioning and Structural Problems

Top 5 Items with Most Discrepancies in Section G

1. G1bA – Transfers/Self-Performance
2. G1aA – Bed Mobility/Self-Performance
3. G1iA – Toilet Use/Self-Performance
4. G1dA – Walk in Room/Self-Performance
5. G1aB – Bed Mobility/Support

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G1 (A): Activities of Daily Living (ADL) Self-Performance

- **Intent:**
  - To record the resident's self-care performance in activities of daily living (i.e., what the resident **actually did** for himself and/or how much verbal or physical help was required by the staff members) during the last seven days.

Definition of ADL Self-Performance

- Measures what the resident actually did (not what he/she might be capable of doing) within each ADL category over the last seven days according to a performance-based scale.

ADL Categories

- Bed Mobility
- Transfer
- Walk in Room
- Walk in Corridor
- Locomotion On Unit
- Locomotion Off Unit
- Dressing
- Eating
- Toilet Use
- Personal Hygiene

Bed Mobility – Review *all* of the Following:

1. How the resident turns from side-to-side in bed.
2. How the resident lays down and sits up when placed in bed.
3. How the resident positions himself in bed, in a recliner, or other type of furniture the resident sleeps in, rather than a bed.

Transfer

- How the resident moves between surfaces:
  - From bed to chair
  - Chair to bed
  - Bed to wheelchair
  - Standing position

- Exclude movement to/from bath or toilet which is covered under Toilet Use and Bathing.

Walking

- Walk in Room (Walk = walking with legs)
  - How much assistance is needed when the resident walks between locations in his/her own room. “Only within the room.”
- Walk in Corridor (Walk = walking with legs)
  - How much assistance is needed when the resident walks in the corridor/hallway on their unit.

Locomotion

- **Locomotion on Unit *(Walking or wheeling once in W/C)***
  - How much assistance is needed when the resident moves between locations in room (like bed to bathroom) and adjacent corridor on same floor.

- **Locomotion off Unit *(Walking or wheeling once in W/C)***
  - How much assistance is needed when the resident moves to and returns from “off unit” activities.
  - If facility has only one floor, locomotion off the unit is defined as how the resident moves to and from distant areas on the floor.

Dressing and Eating

- **Dressing**
  - How the resident puts on, fastens, and takes off all items of clothing, including donning/removing a prosthesis.
  - Dressing includes putting on and changing pajamas and housedresses.
- **Eating**
  - How resident eats and drinks, regardless of skill.
  - The ability to get food into their body.
  - Includes intake of nourishment by other means i.e., tube feeding, total parenteral nutrition, etc.
  - Resident must be evaluated under eating ADL category for level of assistance in the process.

Toilet Use

- How the resident uses bathroom, commode, bedpan or urinal?
- How does the resident transfer on/off toilet?
- How much assistance is needed to clean themselves afterwards?
- How much assistance is needed when the resident pulls down or pulls up clothing?
- How much assistance is needed when the resident changes pads, manages ostomy or catheter?

Note:

- Do not limit assessment to bathroom use only.
- Elimination occurs in many settings and includes transferring on/off toilet, cleansing, changing pads, managing ostomy, or catheter and adjusting clothing.

Personal Hygiene

- How much assistance is needed when the resident:
  - Combs his hair?
  - Brushes his teeth?
  - Shaves?
  - Applies makeup?
  - Washes / dries his face, hands and perineum?

Note:

- Exclude from this definition personal hygiene in baths and showers, which is covered under Bathing.

G1A: ADL Self-Performance – Process

- In order to promote the highest level of functioning among residents, clinical staff must first identify what the resident actually does for himself or herself.
  - Noting when assistance is received.
  - Clarifying the types of assistance provided (verbal cueing, physical support, etc).
  - Self-performance can vary day to day, shift to shift or within shifts.
  - Need to capture the total picture of the resident's ADL self-performance over the 7 day period, 24 hours a day.

Coding

For each ADL category, code the appropriate response for the resident's actual performance during the past 7 days.

- **Self Column -- Self-Performance**
  - It stands for how much the resident did for themselves, with or without help.

- **Assist Column -- Staff Support**
  - The number of staff members it takes to assist or help a resident.

ADL Coding: Self-Performance

- **Independent**
  - No help or staff oversight (physical or verbal).
  - Resident is able to perform the activity with or without setup from staff.

--or—

  - Staff help or oversight provided only 1 to 2 times during the last 7 days.
  - Resident is usually able to do tasks with no verbal instructions or physical assistance by staff.

Examples of Independent Self-Performance

- You take a resident's meal tray to his table and set it in front of him. You only open the milk carton. The resident begins eating the meal by himself without needing any verbal or physical help.

- You assist a resident by setting out his shoes. The resident is able to put on his shoes and tie them without any staff assistance.

- The resident is able to brush his teeth as well as comb his hair without any staff assistance.

ADL Coding: Self-Performance

- **Supervision**
  - Oversight, monitoring, encouraging, verbally prompting or cueing 3 or more times during the last 7 days

--or--

  - (3 or more times) plus physical assistance provided, but only 1 or 2 times during the last 7 days

Self-Performance: Supervision

Supervision: Monitoring, encouraging, verbally prompting or cueing

Examples:

- Staff must tell a resident to get dressed, even though the clothes are laying out. Once told by staff to get dressed, resident is able to dress himself.

- A plate of food sits in front of a resident, but yet the resident is not eating. Staff members must tell resident to start eating…or pick up the fork and start eating. Once told by staff, the resident begins.

ADL Coding: Self-Performance

- **Limited Assistance**
  - Resident highly involved in activity, received physical help in guided maneuvering of limbs or other non weight bearing assistance on 3 or more occasions.

--or—

  - Limited assistance (3 or more times), plus more weight bearing support provided, but only 1 or 2 times during the last 7 days.

Self-Performance: Limited Assistance

Limited Assistance: Physical prompting or Physically guiding

Examples:

- Non-weight bearing help. Staff do not bear any of the resident's weight when assisting resident to perform task.

- Staff must set up the tray, cut the meat, open the containers and hand him the utensils. Staff must encourage him to continue to eat and frequently hand him his utensils and cups to complete the meal, in order to ensure adequate intake.

Self-Performance: Extensive Assistance

- **Extensive Assistance**
  - While resident performed part of the activity over last 7 days, help of the following type(s) was provided 3 or more times:
    - Weight bearing support provided 3 or more times
    - Full staff performance to activity (3 or more times) during part (but not all) of last 7 days

Self Performance: Extensive Assistance

Extensive Assistance:

- Staff providing physical weight-bearing assistance for resident to help complete task.
- While the resident helps in the activity, staff provide some partial physical support of the resident. In this case, the resident is NOT TOTALLY DEPENDENT on staff to do the activity.

Examples:

- To help repositioning in bed, a resident may help push with his feet while staff members help lift him to the top of the bed.
- When putting on his pants, a resident may be able to place his left leg in the pants, but has difficulty with his right leg due to a stroke. Staff members must lift his leg and put it into the pants.

Self-Performance: Total Dependence

- **Total Dependence**
  - Full Staff Performance during entire 7 day period.
  - No assistance or participation from resident.
  - Facility staff perform / complete entire ADL task for resident.

Examples:

- 2 staff members must totally dress a 425lb. man. He is unable to put his arms through sleeves or cannot lift his legs to put into his pant legs.

- A resident cannot transfer themselves out of the bed. Staff members must use a Hoyer lift to transfer them to a G-chair.

Self-Performance: Activity Did Not Occur

- **Activity Did Not Occur**
  - The activity was not performed by either the resident or the staff member.
  - Neither staff nor resident performed that ADL task during the entire shift.

Example:

- A resident is on bed rest. Staff did not transfer or walk the resident. Staff members would code the transfer and all walking activities as "Activity Did Not Occur."

G1 (B): ADL Support – Intent and Definition

- **Intent:**
  - Record the type and highest level of support the resident received in each ADL activity over the last 7 days.

Definition:

- **ADL Support Provided:**
  - Measures the highest level of support by staff over the last 7 days even if that level of support only occurred once. **This is a different scale, and is entirely separate from the ADL Self-Performance assessment.**
- **Set-Up Help:**
  - The type of help characterized by providing the resident with articles, devices or preparation necessary for greater resident self-performance in an activity.
  - This can include giving or holding out an item that the resident takes from the caregiver.

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G1 (B): ADL Support Provided – Process

- **Process:**
  - For each ADL category, code the maximum amount of support the resident received over the last 7 days irrespective of frequency.
  - Consider all nursing shifts, 24 hours per day, including weekends.
  - Code independently of resident's Self-Performance evaluation.

For example:

- Resident could have been Independent in ADL Self-Performance in Transfer but received a 1 person physical assist 1 or 2 times during the 7 day period.
- Therefore, the ADL Self-Performance Coding for Transfer would be "0" (Independent), and the ADL Support coding "2" (1 person physical assist).

G1 (B): ADL Support Provided – Coding

The highest code of physical assistance in this category (other than the “8” code) is a code of “3”, not “4” as in Self-Performance.

- **0** - No Setup or Physical Help from Staff
- **1** - Setup Help Only-Resident provided with materials or devices necessary to perform the activity of daily living independently
- **2** - 1 person Physical Assist
- **3** - 2+ Persons Physical Assist
- **8** - ADL Activity Itself Did Not Occur

G1 (B): ADL Support Provided – Clarifications

- General supervision in the dining room is not the same as individual supervision of a resident.
- Key to the differentiation between guided maneuvering and weight bearing assistance is determining *who* is supporting the weight of the resident's hand.
- If therapists are involved with the resident, their input should be included either by way of an interview or by the assessor reviewing the therapy documentation. When discussing a resident's ADL performance with a therapist, make sure the therapist's information can be expressed in MDS terminology.

G2: Bathing

- The ***only*** *ADL* activity for which the ADL Self-Performance codes in item G1A do not apply.
- Unique set of Self-Performance codes, to be used ***only*** in the Bathing assessment.
- ADL Support codes given in G1B, continue to apply to the Bathing activity.

G2: Bathing – Intent

Record the resident's Self-Performance and Support provided in bathing, including:

- How well does the resident take a full-body bath or shower or sponge bath?
- How well does the resident transfer in & out of tub or shower?
- Do not include the washing of back or hair.

G2: Bathing – Coding

- **A. Bathing Self-Performance**
  - Reflect the maximum amount of assistance the resident received during bathing episodes:
    - 0 – Independent—No help provided.
    - 1 – Supervision—Oversight help only.
    - 2 – Physical help limited to transfer only
    - 3 – Physical help in part of bathing activity
    - 4 – Total dependence
    - 8 – Activity did not occur during entire 7 days
- **B. Support**
  - Score maximum amount of support provided in bathing activities using the ADL Support Scale (Item G1B).

Other Items in Section G

- Baseline ADL function with other assessment information in Section G, helps to determine resident needs and strengths.
- Important for the determination of different types of therapy services.
- Important for Quality of Life and Quality of Care.
- Significant for care planning.

Other Items in Section G Contribute to Care Planning

- **Body Control Problems**
  - Structural impairments that affect resident self performance
- **Contractures**
- **Mobility Appliances and Devices**
- **Task Segmentation**
  - Presenting ADL tasks in small steps or segments that allows the resident to participate.
- **ADL Rehabilitation Potential**

Common Reasons for Discrepancies

- Not using 7 day look back period
- Not capturing what the resident performed throughout the 3 shifts per day during the full look back period
- Coding ADL self-performance based on what facility clinicians feel the resident is capable of VS. what the resident actually did perform
- Contradictions within the various disciplines documentation
- Lack of documentation to support the coding on the MDS

Reference Source: RAI Manual, August 2003, page 3-76

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DAVE Reconciliation

Section G of the MDS Assessment



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